U.S. Department of Labor

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Issue Date: 03 March 2005

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In the Matter of:

VIRGINIA BEA MATNEY, widow of
SHERMAN MATNEY, deceased
Claimant,

v. **Case No. 2003-BLA-06547**

CLINCHFIELD COAL CO.,
Employer, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party in Interest.

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Appearances:

Joseph Wolfe, Williamson and Rutherford, Norton, VA
For Claimant

Timothy W. Gresham, Penn Stuart & Eskridge, Abingdon, VA
For Employer

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a survivor's claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by Claimant Virginia Bea Matney ("Claimant") on March 26, 2001 based upon the death of her husband Sherman Matney ("Miner"). The putative responsible operator is Clinchfield Coal Company ("Employer").

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also

applicable, as this claim was filed after January 19, 2001.[1] 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The Department of Labor amended the regulations on December 15, 2003, solely for the purposes of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law hereafter are based upon my analysis of the entire record, except as limited below in view of the new evidentiary limitations. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant Virginia Bea Matney filed the instant claim for survivor's benefits (hereafter "Widow's claim") on March 12, 2001, based upon the death of her husband, Sherman Matney, on February 1, 2001. (DX4). The District Director initially concluded that based on the current evidence, the Claimant would be entitled to benefits and the Employer was the responsible operator. (DX26). On February 26, 2003 the District Director issued a Proposed Decision and Order awarding benefits to the Claimant. (DX31). The District Director found that the Miner contracted pneumoconiosis as a result of his coal mine work, that such disease caused the miner's death within the meaning of the Act, that Employer was the responsible operator, and that the Miner had 23 years of coal mine work experience. *Id.*

At the time of his death, the deceased Miner was receiving Black Lung benefits based upon the third of three claims he filed during his lifetime. He first filed for Black Lung Benefits on April 3, 1980; that claim was denied by the District Director on February 6, 1981. (DX1). On March 30, 1992, the Miner filed a second application for Black Lung Benefits, which was also subsequently denied by the District Director on February 11, 1993. (DX2). On March 24, 1994, the Miner filed a third application for Black Lung Benefits, and the claim was denied by the District Director on November 18, 1994. (DX3). The Miner appealed the decision to the Office of Administrative Law Judges, and benefits were granted on June 20, 1996 by Administrative Law Judge ("ALJ") Frederick D. Neusner. *Matney v. Clinchfield Coal Co.,* 1995-BLA-1472 (ALJ, June 20, 1996). Employer appealed the Award of Benefits on July 15, 1995 to the Benefits Review Board ("Board"), and the Board remanded the decision for reconsideration. *Matney v. Clinchfield Coal Co.,* BRB No. 96-1349 BLA (June 16, 1997) (unpub.). On November 12, 1997 Judge Neusner issued the Second Decision and Order granting benefits, and the Employer again appealed the decision to the Board. *Matney v. Clinchfield Coal Co.,* 1995-BLA-1472 (ALJ, Nov. 17, 1997). The Board issued another decision, which remanded the case for the second time. *Matney v. Clinchfield Coal Co.,* BRB No. 98-0423 BLA (May 17, 1999) (unpub.). On September 20, 1999 Judge Neusner issued a Decision and Order After Second Remand granting benefits. On appeal, the Board affirmed Judge Neusner's third decision. *Matney v. Clinchfield Coal Co.,* BRB No. 00-0190 BLA (Oct. 20, 2000) (unpub.).

[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

A hearing in the above-captioned matter was held on March 1, 2004 in Abingdon, Virginia.[3] At the hearing, Director's Exhibit 1 through 42 ("DX 1" through "DX 42") and Employer's Exhibit 1 through 6 ("EX 1" through "EX 6") were admitted into evidence.[4] The parties agreed to have a hearing on the record. (Tr. at 5). The Employer was given 30 days to submit a brief in the case and Claimant was allowed 30 days to file any response. (Tr. at 13). Additional extensions of time were informally granted by the undersigned in correspondence of March 30, 2004 and June 24, 2004, which allowed the Employer until July 7, 2004 to submit a brief or written closing argument and gave the Claimant until August 7, 2004 to respond. Under cover letter of July 7, 2004, filed on July 13, 2004, Employer submitted a brief, which is accepted as timely filed. No brief or written closing argument was submitted on behalf of the Claimant.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The issues before the undersigned are as follows: the existence of pneumoconiosis, the causal relationship between pneumoconiosis and coal mine employment, and the causation of the miner's death.[5] (Tr. at 8). In addition, the issue of whether collateral estoppel bars the relitigation of the issue concerning the existence of pneumoconiosis was also raised. (Tr. at 10-13). The parties stipulated to 23 years of coal mine employment. (Tr. at 8).

Medical Evidence

The medical evidence submitted in connection with the Widow's claim consists of interpretations of x-rays taken on April 5, 1994, November 20, 2000, December 24, 2000, and January 2, 2001; arterial blood gases taken on November 20, 2000 and December 24, 2000; the medical opinion reports of J.G. Patel, M.D. (dated October 2, 2001), James Castle, M.D. (dated September 27, 2002) and Gregory Fino (dated February 4, 2004); the transcripts of the depositions of Drs. Patel and Castle; the Miner's death certificate, dated February 1, 2001; the Miner's hospital records (including discharge summaries and electrocardiograms) from October 20, 2000 to January 15, 2001; cytology reports of February 19 to 23, 1999; and Dr. Fino's report relating to a February 16, 1999 CT scan.

In addition to the above, medical evidence was submitted in connection with the claims that the Miner filed during his lifetime.

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[3] References to the hearing transcript of the March 1, 2004 hearing appear as "Tr." followed by the page number.

[4] A List of Director's Exhibits 1 through 40 appears in Director's Exhibit 41. Employer's Exhibits consist of EX 1 (x-ray reading by Dr. Fino); EX 2 (Curriculum Vitae of Dr. Castle); EX 3 (2/4/04 medical report of Dr. Fino); EX 4 (deposition transcript of Dr. J.G. Patel); EX 5 (Notice of deposition dated 1/9/04); and EX 6 (deposition transcript of Dr. Castle).

[5] At the hearing, the Employer withdrew the issues of dependency, survivor, and responsible operator, which had been listed on the transmittal form CM-1025. (Tr. 8; EX 40). However, Employer continued to assert issues listed under "Other Issues," concerning the applicability and validity of the revised regulations, for appellate purposes. *Id.*

The effect of the evidentiary limitations (appearing in the amended regulations) upon my consideration of the evidence is discussed below.

Background and Employment History

Claimant is the widow of the deceased miner, Sherman Matney. (DX 4). The Miner died on February 1, 2001 at the age of 79. *Id.* No autopsy was performed. *Id.* During the Miner's lifetime, he filed for black lung benefits on three occasions. (DX 1, 2, 3). At the time he filed his first claim, in 1980, he was still employed in the mines. (DX 1). He was granted benefits based upon his third claim by Judge Neusner; the Board affirmed the award of benefits on October 20, 2000 after two prior remands. *Matney v. Clinchfield Coal Co.,* BRB No. 00-0190 BLA (Oct. 20, 2000) (unpub.). (DX 3).

In connection with his March 1994 claim, the Miner testified at a hearing before Judge Neusner conducted on March 6, 1996. (DX 3; Transcript of March 6, 1996 Hearing). The Miner claimed to have been employed underground in the coal mines for 55 years.[6] (*Id.* at 17). He testified that he was born in 1921 and that he first started working in the mines at age 18, in approximately 1939. (*Id.* at 18). On January 16, 1992, the Miner retired due to shortness of breath. (*Id.* at 18-19, 25, 33). At the time he left the mines, he was employed as a long wall jack setter. (*Id* at 19). As a jack setter, the Miner was required to set jacks along the wall of the mine. (*Id.* at 19-20-23). The job required him to stand and walk along the side of the mine several times per day. (*Id.)* He would be required to walk about six hundred feet from one end of the wall to another while operating hand jacks to reposition the miner or shearer. (*Id.)* Sometimes he would have to rest two or three times to catch his breath. (*Id.*) The Miner testified that by the time of the hearing, he would become short of breath walking up six or seven stairs and he was unable to walk uphill. (*Id* at 29*.)* In addition, he reported that he had a breathing machine and had to use inhalers three times per day. (*Id.* at 26). The Miner testified that he "didn't smoke 2 cigarettes in his life" and never took up smoking.[7](*Id.* at 30.)

Records from the Social Security Administration (dating from 1960) and from Clinchfield Coal Company reflect that `(apart from two periods consisting of approximately six months) the Miner was continuously employed by Clinchfield from April 1970 through January 1992. (DX 6, 7, 8). Prior to his employment with Clinchfield, he was employed by other coal mine employers, including Hursel Justus Coal Co. and Slate Creek Coal Co. (DX 8)

Discussion and Analysis

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001, including survivor's claims. 20

[6] The parties stipulated to 23 years of coal mine employment. (Tr. at 8). The Social Security records obtained only go back to 1960 and reflect employment other than coal mine employment. However, it appears that the Miner documented 26 years of coal mine employment based upon quarters reflected in the Social Security records. (DX 8).
[7] Although the Miner's smoking history is variously reported as nonexistent or amounting to several cigarettes a day for a period of years, I find that the Miner's smoking history is minimal.

C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.,* 21 BLR --, BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3)*, citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id., citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id., citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id., citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id., citing* 20 C.F.R. §725.456(b)(1). The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.,* 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra.* First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; s*ee* 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Further, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. However, the Board found that records from a state claim were properly excluded as they did not fall within the exception for hospitalization or treatment records or the exception for prior federal black lung claim evidence (under 20 C.F.R. §725.309(d)(1)). *Dempsey* at 6. On the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be "helpful and necessary" for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Id.* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was "inextricably intertwined" with excluded evidence. *Id*. at 9. Referencing *Peabody Coal Co. v. Durbin,* 165 F.3d 1126, 21 BLR 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because

"[t]he revised regulations limit the scope of expert testimony to admissible evidence." *Dempsey* at 9-11.

As the Board noted, the regulations specifically allow evidence from a prior claim to be considered in connection with a later claim, so that a determination may be made whether there has been a material change in conditions since the time of the prior claim. 20 C.F.R. §725.309(d)(1). However, there is no such provision applicable to survivor's claims that would allow consideration of the evidence developed in the miner's claims, absent a finding of good cause.

Consistent with the above limitations and the Board's decision in *Dempsey*, other administrative law judges have generally excluded evidence developed in connection with a miner's claim from consideration in a surviving spouse's claim to the extent that the limitations have been exceeded. *See Brewster v. Consolidation Coal Co.,* 2004-BLA-05361 (ALJ Solomon Feb. 16, 2005) (finding evidence from miner's claim unduly repetitious and finding no good cause to exceed limitations); *Duncan v. West Coal Corp.*, 2004-BLA-05355 (ALJ Miller Jan. 18, 2005) (noting strong policy reasons for excluding evidence from a miner's claim in a survivor's claim, which is "an independent claim subject to independent analysis"); *Howard v. P & C Mining Co.,* 2003-BLA-05436 (ALJ Kane Dec. 29, 2004) (excluding excess evidence except for treatment records and prohibiting rebuttal to treatment records); *Griffin v. Island Coal Company,* 2003-BLA-5503 (ALJ Phalen July 22, 2004) (excluding excess reports, excess test results, and deposition testimony relying upon inadmissible evidence). However, Administrative Law Judge Robert L. Hillyard found good cause for consolidating a miner's claim with a survivor's claim and for exceeding the evidentiary limitations in the consolidated claims, in *Clark v. Peabody Coal Company,* 2002-BLA-05114 (ALJ Hillyard, Nov. 30, 2004).

At the hearing in the instant case, there being no objection, all of the Director's Exhibits (DX1 to DX42) were admitted into evidence along with six exhibits from the Employer. The Director's Exhibits included the medical records from the three Miner's claims as well as the evidence submitted in connection with the Widow's claim that is now before me. The exhibits included numerous x-rays, blood gas studies, pulmonary function tests, and medical reports in excess of the evidentiary limitations. However, the District Director's proposed decision was based on the medical records submitted in the survivor's claim only and consideration was not given to the medical records of the living miner's claims. (DX 31).

In view of the authority cited above, I will not consider the evidence from the Miner's claim with respect to each category of evidence for which there are limitations. As I address the issues presented in this decision, I will decide whether special circumstances exist that give rise to good cause for consideration of evidence from the Miner's claim.

Some of the medical evidence submitted in connection with the instant Widow's claim is not in compliance with the evidentiary limitations. The District Director considered two readings for each of two x-rays (dated November 20, 2000 and January 2, 2001), two arterial blood gas studies (dated November 20, 2000 and December 24, 2000), two medical reports (the October 20, 2001 report by Dr. J.G. Patel and the September 27, 2002 report by Dr. James

Castle, misidentified as Dr. Gregory Fino's report), hospital records, and the death certificate.[8] Claimant did not designate evidence to be considered and has relied upon that designated by the District Director. The medical evidence designated or submitted by the Employer is in compliance with the numerical evidentiary limitations set forth in regulations; that evidence includes the interpretations of one x-ray (Dr. Fino's October 1, 1995 interpretation of an April 5, 1994 x-ray),[9] two medical reports (the medical reports of Dr. Fino dated February 4, 2004 and Dr. Castle dated September 27, 2002), two deposition transcripts (of Dr. Patel, offered as rebuttal, and of Dr. Castle, not designated but submitted at the hearing), one CT scan interpretation, and various medical records (including EKGs and cytology reports). There is no limitation on CT scans or hospital records. The medical reports of Ds. Fino and Castle constitute the Employer's two medical reports allowed under the regulations, and the deposition transcript of Dr. Patel constitutes its rebuttal evidence to the Claimant's October 2, 2001 report by Dr. Patel. While not designated prior to the hearing, the transcript of the deposition of Dr. Castle is admissible as the equivalent of testimony, which is not precluded by the regulations.

The problem is that the above reports and deposition transcripts, while not exceeding the evidentiary limitations, reference evidence that is not otherwise admissible, contrary to section 718.414. Both subsection (a)(2)(i) (relating to evidence admissible on behalf of a claimant) and (a)(3)(i) (relating to evidence admissible on behalf of a responsible operator) provide the following:

> . . . Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph [providing the limitations] or paragraph (a)(4) of this section [allowing admission of "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease" notwithstanding the limitations in (a)(2) and (a)(3)]. . . .

As *Dempsey* noted, the section does not state what is to be done with a medical report that is not in compliance with this requirement and it would be within my discretion to exclude such a report if the physician's opinion were "inexplicably intertwined" with the inadmissible evidence. Accordingly, I will consider the extent to which the impermissible evidence is inextricably intertwined with the expert's medical opinion (whether stated in a report or at a deposition) when addressing the merits of the claim.

In addition to the above, a reading of a December 24, 2000 x-ray by Dr. Barrett has not been designated by any party and was not considered by the District Director. (DX 20). It will be excluded from consideration.

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[8] The medical evidence considered by the Director is summarized in DX 31.

[9] On the Black Lung Benefits Act Evidence Summary Form, Employer designated only one x-ray reading (Dr. Fino's interpretation of an April 5, 1994 x-ray) but included that reading as "rebuttal of Department-sponsored chest x-ray study.". However, although that x-ray is offered as rebuttal of a Department-sponsored x-ray, the readings relating to that x-ray have only been offered in connection with the Miner's claim and were not designated or considered by the District Director in connection with the instant claim.

Collateral Estoppel

Claimant contends that the doctrine of collateral estoppel bars the relitigation of the issue of the existence of pneumoconiosis, because an administrative law judge made a finding regarding the existence of the disease as a part of the living miner's claim (in which the Employer participated). (Tr. at 11); *see also Matney v. Clinchfield Coal Co.*, 1995-BLA-1472 (ALJ Neusner, September 20, 1999), *aff'd* BRB No. 00-0190 BLA (BRB Oct. 20, 2000) (unpub.) (DX 3). Therefore, Claimant argued at the hearing that the issue should not be relitigated in this proceeding. (Tr. at 11). Employer presented a brief argument on why collateral estoppel does not apply in this case at the hearing, and I allowed both parties to submit briefs on the issue. *Id.* at 12. Employer fully briefed this issue in its closing brief. *Id*.

Collateral estoppel forecloses "the relitigation of issues of fact or law that are identical to issues which have been actually determined and necessarily decided in prior litigation in which the party against whom [issue preclusion] is asserted had a full and fair opportunity to litigate." *Ramsey v. INS,* 14 F.3d 206 (4th Cir. 1994); *see Virginia Hosp. Ass'n v. Baliles,* 830 F.2d 1308 (4th Cir. 1987). For collateral estoppel to apply in the present case, which arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit, the claimant must establish that:

(1) the issue sought to be precluded is identical to one previously litigated;
(2) the issue was actually determined in the prior proceeding;
(3) the issue was a critical and necessary part of the judgment in the prior proceeding;
(4) the prior judgment is final and valid; and
(5) the party against whom estoppel is asserted had a full and fair opportunity to litigate the issue in the previous forum.

Additionally, it is well-settled that relitigation of an issue is not barred when there is a difference in the allocation of the burdens of proof and production, or a difference in the substantive legal standards pertaining to the two proceedings. *Smith v. Sea B Mining Co.,* BRB No. 04-0230 BLA (Nov.30, 2004) (unpub.), *citing Collins v. Pond Creek Mining Co.,* 22 BLR 1-229, 1-232 (2003).

The Board has held that a prior finding of pneumoconiosis before the establishment of the *Compton* standard is not identical for the purposes of collateral estoppel to current findings of pneumoconiosis due to the change in the standard of proof. *Surway v. United Pocahontas Coal Co.*, BRB No. 01-0881 BLA (Jun. 26, 2002) (unpub.). In *Island Creek Coal Co. v. Compton*, 211 F.3d 302, (4th Cir. 2000), the Fourth Circuit held that based upon the statutory language at 30 U.S.C. §923(b), all relevant evidence is to be considered together rather than merely within discrete subsections of 20 C.F.R. §718.202 (a)(1)-(4) in determining whether a claimant has met his or her burden of establishing the existence of pneumoconiosis by a preponderance of all of the evidence. Before this holding, the Board's precedent stood for the proposition that a claimant could prove pneumoconiosis under one of the four methods pursuant to Section 718.202 (a)(1)-(4) obviating the need to provide proof under all four categories. *See Dixon v. North Camp Coal Co.,* 8 BLR 1-344 (1985); *see also Surway v. United Pocahontas Coal Co.*, BRB No. 01-0881 BLA (Jun. 26, 2002) (unpub.). In this case, Judge Neusner's finding was issued on September 20, 1999, prior to the *Compton* standard, and he made a finding of pneumoconiosis

based upon the medical opinion evidence under subsection (a)(4) alone. (*Matney v. Clinchfield Coal Co.*, 1995-BLA-1472 (ALJ Neusner, September 20, 1999), DX 3). Therefore, the issue is not identical due to the change in law.

Inasmuch as the prerequisite for application of the doctrine of collateral estoppel is not met, collateral estoppel does not apply. Hence, the prior finding of pneumoconiosis in the living miner's claim is not binding in this proceeding, and the existence of pneumoconiosis must be proven by the Claimant by the preponderance of evidence.

Merits of the Claim

To prevail in a survivor's claim for Black Lung benefits, a Claimant must establish that the miner had pneumoconiosis; that the miner's pneumoconiosis arose out of coal mine employment; and that the miner's death was due to pneumoconiosis. 20 C.F.R. §718.205. For survivor's claims filed on or after January 1, 1982, the miner's death will be considered due to pneumoconiosis if pneumoconiosis was the cause of the miner's death, it was a substantially contributing cause or factor leading to the miner's death, or death was caused by complications of pneumoconiosis. Pneumoconiosis is deemed to be a substantially contributing cause of death if it hastened the miner's death. 20 C.F.R. §718.205(c)(5). Causation may also be established presumptively, under the presumptions relating to complicated pneumoconiosis, set forth at §718.304. 20 C.F.R. §718.205 (c)(1)-(3).

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Greenwich Collieries*, the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

Existence of Pneumoconiosis

For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical or clinical pneumoconiosis and statutory or legal pneumoconiosis. 20 C.F.R. §718.201. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconioses, *i.e*. the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. *Id*. Legal pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment, and the definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. *Id.*

Under 20 C.F.R. §718.202(a)(1)-(4), a finding of pneumoconiosis can be made based upon x-ray evidence, biopsy or autopsy evidence, presumption, or the reasoned medical opinion of a physician based on objective medical evidence.

X-Ray Evidence. Claimant has not established pneumoconiosis by a preponderance of the x-ray evidence submitted in connection with the claim. The x-ray evidence consists of the following[10]:

Exhibit No.	Date of X-ray/ Date of Reading	Physician Qualifications	Interpretations
DX 19	January 2, 2001/ June 10, 2001	S. Navani B-Reader & Board-Certified Radiologist	Negative for pneumoconiosis; changes of C. H. (congestive heart) failure; level 3 (quality).
DX 18	January 2, 2001/ same	D.B. Patel Hospital Radiologist	[Not on ILO Form] Underlying chronic interstitial disease is evident; clearing in right lower lobe infiltration; possible right hydrothorax
DX 17	Nov. 20, 2000/ May 11, 2001	Peter J. Barrett B-Reader & Board-Certified Radiologist	Negative for pneumoconiosis; emphysema; level 2 (quality).
DX 16	Nov. 20, 2000/ same	Dilip R. Patel Hospital Radiologist	[Not on ILO Form] Changes of chronic bronchitis
EX 1	April 5, 1994/ October 1, 1995	Gregory J. Fino B-Reader	Completely negative

All of the x-ray readings submitted in connection with the instant claim are negative for the existence of the disease under the regulatory requirements. Although Dr. Dilip Patel's finding of "chronic interstitial disease" is equivocal, such a finding is insufficient to establish pneumoconiosis under the regulations, and the x-ray reading itself is insufficient as it does not utilize the ILO system. *See* 20 C.F.R. § 718.102. Thus, Claimant has failed to meet the preponderance of the evidence standard in establishing pneumoconiosis, and Claimant cannot prevail under 20 C.F.R. §718.202(a)(1).

Autopsy or Biopsy Evidence. As there is no autopsy or biopsy evidence of record, Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2).

Complicated Pneumoconiosis and Other Presumptions. A finding of opacities of a size that would qualify as "complicated pneumoconiosis" under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. As there is no evidence of complicated

[10] The readings by Dr. Dilip R. Patel or D.B. (sic) Patel that were designated by the District Director were hospital records (from Buchanan General Hospital) and did not utilize the ILO system. (DX 16, DX 18). Also, as noted above, Dr. Barrett's reading of the December 20, 2000 x-ray has been excluded. (DX 20).

pneumoconiosis, the section 718.304 presumption is inapplicable. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306 are also inapplicable, *inter alia*, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively. Further, section 718.306 does not apply, because the miner did not die on or before March 1, 1978. Thus, Claimant has failed to establish the presence of pneumoconiosis under 20 C.F.R. §718.202(a)(3).

Medical Opinions on Pneumoconiosis. Moreover, I find that the medical opinion evidence does not, by a preponderance of the evidence, establish pneumoconiosis. The following physicians provided medical opinions addressing the issue of whether Claimant has pneumoconiosis:

- Dr. Gregory J. Fino, submitted a February 4, 2004 medical report based upon the review of the Miner's medical records. (EX 3).
- Dr. J.G. Patel, submitted an October 2, 2001 medical report as the Miner's treating physician and had his deposition taken on January 27, 2004. (DX 14, EX 4).
- Dr. James Castle, M.D. prepared a report dated September 27, 2002 and had his deposition taken on February 23, 2003. (DX 30, EX 6).

(1) **Gregory J. Fino, M.D.**, a board certified pulmonologist,[11] submitted a medical report dated February 4, 2004. (EX 3). He concluded in the medical report that there was insufficient objective medical evidence to justify a diagnosis of simple coal worker's pneumoconiosis ("CWP"). He further opined that the Miner's disabling lung disease was due to asthma and that lung disease was a participating cause of death; however, he believed that coal mine dust inhalation did not cause or hasten the Miner's death. Dr. Fino's conclusions were based upon the review of the medical records and radiographic studies, including records from the Miner's claim that cannot be considered by virtue of the evidentiary limitations. The medical report summarized the medical evidence including radiographic reports, pulmonary function studies, arterial blood gas studies, medical reports, deposition testimony, CT scan reports, hospital records, and death certificate. In support of his opinion that the Miner had severe COPD secondary to asthma and not a coal mine dust related pulmonary condition, he provided the following reasons:

> 1. The chest x-rays were negative for CWP and the FEV1 loss (on pulmonary function testing) was insignificant.
> 2. Pulmonary function tests showed significant improvement following bronchodilator, and coal mine dust related pulmonary conditions are irreversible.
> 3. The reversible nature of the Miner's condition is consistent with asthma, as is the fixed obstruction due to airway remodeling which afflicts 10% of asthmatics.
> 4. The variability of the pO2 values during exercise (on arterial blood gas testing) is consistent with asthma.

(EX 3). Dr. Fino previously expressed opinions in a September 21, 1995 report that was submitted in connection with the Miner's last claim. (DX 3).

[11] As used herein, a board-certified pulmonologist is a physician who is board-certified in internal medicine and the subspecialty of pulmonary diseases.

(2) **J.G. Patel, M.D.**, a board-certified pulmonologist and the Miner's treating physician, submitted a medical report dated October 2, 2001. He stated in the medical report that the Miner had a known history of CWP, COPD [chronic obstructive pulmonary disease], longstanding hypertension, and other diseases. It was further stated that the most likely explanation of Miner's death would be cardiac arrhythmia precipitated by his underlying cardiopulmonary disease. At the time of the Miner's last hospital discharge, he was on oxygen supplement two liters per minute by nasal cannula. Dr. Patel concluded that CWP contributed to the Miner's death. (DX 14). Dr. Patel's medical report of November 24, 1993 was submitted in connection with the Miner's third claim. (DX 3).

Dr. Patel also had his deposition taken on January 27, 2004. (EX 4). Dr. Patel testified concerning the Miner's pulmonary conditions, smoking history, medical treatment, and cause of death. He testified that he first treated the Miner on January 7, 1993. *Id.* at 4. He also discussed the Miner's hospitalizations and stated that the Miner had a history of hospitalization due to wheezing and shortness of breath dating back to December 21, 1998. *Id.* at 11-12. In addition, he stated that the Miner also suffered from aortostenosis and coronary artery disease. *Id.* at 14. Dr. Patel explained that the discharge diagnosis of "CWP from history" was based upon a 1993 x-ray by Dr. Dilip R. Patel and the Miner's history of coal dust exposure. *Id.* at 15-18. He had accepted the history of CWP at the first time he saw the Miner because he was drawing black lung benefits. *Id.* at 15-16.

Dr. Patel also offered testimony concerning the difference between obstructive and restrictive pulmonary conditions. He stated that obstructive disease responds to bronchodilators. *Id.* at 18. Improvement from bronchodilators that is more than 12 percent is considered a good response, and a five to six percent response is considered partially reversible obstructive disease. *Id.* Restrictive lung disease is when the lung capacity is reduced due to scarring. *Id.* at 19. It is also possible to have both obstructive and restrictive lung disease. *Id.* Normally, reversible obstructive disease is not due to pneumoconiosis. *Id.* CWP usually results in an interstitial scarring process and fibrosis. *Id.* He agreed that the Miner's 23% FEV1 from the November 1992 pulmonary function test was a significant improvement. *Id*. at 21. He stated that asthmatic conditions usually show a 20 to 23 percent improvement. *Id.* at 21. People with simple bronchitis may also show improvements with bronchodilators. *Id*. at 22.

During cross examination, Dr. Patel stated that the Miner's amount of improvement with bronchodilators lessened over the years. *Id.* at 24-25. He further stated that persons with COPD may have a 5 percent, 7 percent, or even 15 to 20 percent response to bronchodilators. *Id.* at 26. Additionally, he testified that coal mine dust (which includes other dusts besides coal dust) can cause a purely obstructive lung disease, although pure coal dust would not. *Id.* at 26-27.

(3) **James Castle, M.D**., a board certified pulmonologist, prepared a report dated September 27, 2002. (DX 30). Dr. Castle stated his medical opinion that the Miner did not suffer from coal workers' pneumoconiosis, that he died as a result of a cardiac arrhythmia due to coronary artery disease and aortic stenosis, and that his death was neither caused, contributed to, nor hastened by CWP or coal dust exposure. Dr. Castle also based his conclusions upon medical records and radiographic studies, which included records from the Miner's claim that exceeded

the evidentiary limitations. The medical report summarized the medical evidence that Dr. Castle reviewed. (DX 30). Dr. Castle had previously examined the Miner on September 5, 1995 in connection with the Miner's third claim, and he expressed his opinion at that time. (DX 3).

Dr. Castle had his deposition taken on February 23, 2004. He summarized his 1995 finding that the Miner did not suffer from pneumoconiosis but asthma based upon markedly reversible airway obstruction and lack of radiographic findings. (EX 6 at 8-9). He stated that the Miner's x-ray revealed a minimal (0/1) increase in irregular opacities -- a nonspecific finding consistent with numerous conditions including bronchial asthma -- while the disease of coal workers' pneumoconiosis usually involves small, round, regular opacities in the upper lung zones. *Id.* at 9-10. He also stated that the Miner's asthma did not derive from coal dust exposure nor was it aggravated by coal dust exposure. *Id.* at 10-11. Further, asthma is an inflammatory airway disease, which may become irreversible if not properly treated. *Id.* at 11-12. He further stated that both asthma and COPD show relatively low FEV1's and low ratios, and normal diffusion capacity is also consistent with asthma. *Id.* at 13.

Dr. Castle also offered testimony on the Miner's cause of death, and it was his opinion that CWP did not contribute to the Miner's death. *Id.* at 14-18. During cross examination, he stated that it was possible for the Miner to work in the coal mine for over 50 years without ever developing the disease, because only a minority of the miners actually are diagnosed with pneumoconiosis. *Id.* at 24-25. He also clarified earlier testimony on cross-examination concerning his x-ray reading by stating that coal dust can not actually be seen and only the lungs' response to a certain amount of coal dust can be detected through x-ray readings. *Id.* at 25-26.

At the outset, I find good cause for waiving the evidentiary limitations to the extent that I will consider the medical reports and depositions of Drs. Fino, Patel, and Castle in their entirety, even though they make reference to evidence that would be otherwise inadmissible, because each of these physicians had expressed opinions in connection with the Miner's claims.[12] It would be impractical to ask these physicians to state hypothetical opinions based solely upon medical information developed in connection with the Widow's claim, in addition to hospital and physicians' office records. Moreover, it would be virtually impossible to ensure that their opinions were not based in part upon medical information they reviewed in connection with the previous Miner's claims. Therefore, in order to understand their opinions fully, it is necessary to know what data they relied upon in formulating their opinions. Furthermore, I find that their opinions retain an independent basis, in view of evidence submitted in connection with the instant Widow's claim, and their opinions cannot be found to be unreliable simply because these physicians also considered inadmissible evidence. However, in considering the opinions of Drs. Fino, Patel and Castle I will not in any way rely upon evidence recounted in their reports or at their depositions that is not admissible except to the extent that it is incorporated in these physicians' conclusions.[13] Thus, for example, while the reports recount x-ray findings, they will not be deemed to be additional x-ray reports for consideration under section 718.202(a)(1).

[12] This matter is discussed above in the section relating to Evidentiary Limitations.

[13] As the Board noted in *Dempsey*, *supra* (slip op. at 9-10), citing *Peabody Coal Co. v. Durbin,* 165 F.3d 1126 (7th Cir. 1999), it is perfectly proper for expert witnesses to consider inadmissible evidence and they are only precluded from doing so because the revised regulations limit the scope of expert testimony to admissible evidence.

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks,* 138 F.3d 524, 536 (4th Cir.1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.,* 10 BLR 1-19, 1-22 (BRB 1987) (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). In addition, the new regulation appearing at 20 C.F.R. §718.104(d) allows additional weight to be given to the opinion of a treating physician but requires certain factors, including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

All three physicians are highly qualified to express opinions on the issue of the etiology and nature of the Miner's lung disease as they are board-certified pulmonologists. In addition, each is qualified as a B-reader and is qualified to interpret pulmonary x-rays.

In consideration of the medical reports submitted, I find that there is insufficient evidence to support a finding of pneumoconiosis. In short, I found the reports of Drs. Fino and Castle to be better reasoned and documented than Dr. Patel's report. While Dr. Patel may be credited with superior knowledge concerning the Miner's pulmonary condition based upon his long-standing relationship as treating physician, his report lacks adequate analysis on the basis for his diagnosis, in contrast to the reports of Drs. Fino and Castle.

In this regard, the medical report of Dr. Fino provided a comprehensive overview of the Miner's medical record and provided detailed analysis. He relied on the inconsistent characteristics, such as irreversibility, negative x-rays, and spirometric findings, to support his conclusion that the Miner did not suffer from CWP. Furthermore, the report stated that his opinion covered and ruled out both the clinical and legal definition of pneumoconiosis. The report enumerated specific and persuasive reasons for his conclusion. In addition, he offered an opinion concerning the Miner's cause of death, which is unrelated to this issue. Overall, I found the report of Dr. Fino to be well-reasoned and documented. He was not deposed.

The medical report of Dr. Castle, like that of Dr. Fino, includes a detailed discussion and analysis of the Miner's medical findings and cogently states the basis for his conclusions. Dr. Castle also stated the basis for his opinions further at his deposition.

Dr. Patel's report stated that the Miner suffered from coal workers' pneumoconiosis, but the report failed to provide any reasoning to support such conclusion. The report stated that the Miner had a known history of CWP, COPD, and other diseases, but the report did not attempt to explain those prior findings. I find the opinion was more relevant to the issue of the cause of the Miner's death, because the letter states in the opening paragraph that its purpose is to state an opinion and impression about the Miner's death. As a result, Dr. Patel did not thoroughly discuss the existence of pneumoconiosis but rather conclusively stated that the Miner had a history of CWP. Under §718.104(d), in weighing the medical evidence, consideration should be given to the nature and duration of Dr. Patel's relationship with the Miner as his treating

physician. Dr. Patel is listed as the treating physician on all hospital records, and he testified that he had treated the Miner since January 7, 1993. (EX 4 at 4.) I find that this long-standing relationship provides him with a basis for rendering a more comprehensive report on the Miner's pulmonary condition. However, Dr. Patel's status as treating physician does not negate the fact the medical report does not explain the findings of CWP or COPD.

Dr. Patel's depositional testimony provided foundational information on CWP, and his opinion warrants special consideration based on his long-standing relationship with the Miner as the treating physician. Nonetheless, I did not find that the testimony helped to establish the existence of the disease. When asked whether his finding of CWP was based solely on the x-ray interpretation and the history he had of coal mine employment and exposure to coal dust during that employment, he testified:

> A. That's one basis. Then when I examined him the first time on January 7...1993, the x-ray showed multiple radicular nodular changes. Going back with the history, history of exposure to coal dust, history of coal worker's pneumoconiosis, and the x-ray findings also led me to believe that the patient had coal workers' pneumoconiosis.

(EX 4 at 18). Dr. Patel mentioned other findings but did not explain whether or how they supported his diagnosis. Thus, Dr. Patel essentially relied upon the x-ray evidence, which I have found to not support a finding of pneumoconiosis, and the length of coal mine employment, which has been discounted by Fourth Circuit precedent *(e.g., Hicks, supra* [finding no basis for ALJ crediting one physician's opinion over another's based upon its consistency with the Claimant's extensive history of coal mine employment and other findings]).

In contrast, Dr. Castle testified as to specific findings that supported his conclusions. I found Dr. Castle's deposition testimony to be very insightful on the alternative diagnosis of asthma, and it sufficiently explained his medical findings based upon the physical examination of the Miner and his medical records.

Accordingly, even if Dr. Patel's opinion is given additional weight based upon his status as treating physician, that factor cannot overcome the lack of analysis and support. I simple find Dr. Castle and Fino to have presented better reasoned and documented opinions. Therefore, I find that the Claimant has failed to prove the existence of pneumoconiosis, clinical or legal, by a preponderance of the medical opinion evidence under section 718.202(a)(4).

Other Evidence of Pneumoconiosis. There is additional medical evidence, consisting of CT scans, a death certificate, cytology reports, electrocardiograms, and hospital records, relevant to the issue of pneumoconiosis.[14] All of this additional evidence was thoroughly considered. I find that the evidence of record is sufficiently detailed to provide an accurate picture of the Miner's medical condition. Further, I do not find good cause to consider the evidence in the

[14] Arterial blood gases were also submitted in connection with the instant claim (as well as the Miner's claims), and additional medical testing was submitted in connection with the Miner's claims. However, these test results, while relevant on the issue of total disability, are not probative on the issue of whether the Miner had coal workers' pneumoconiosis absent a physician's opinion interpreting their significance.

Miner's claim that has been excluded by virtue of the evidentiary limitations in the revised regulations. Thus, I will only consider the "other evidence" submitted in the Widow's claim.

First, a CT scan interpretation (dated August 12, 2002) by Dr. Fino relating to a February 16, 1999 CT scan was submitted. (DX 30). Dr. Fino noted that the study was negative for coal workers' pneumoconiosis and concluded: "There were no changes consistent with a coal mine dust associated occupational lung disease." *Id.* No other interpretations of the February 16, 1999 CT scan are of record. Thus, the CT scan evidence does not support a finding of pneumoconiosis.

Second, the death certificate lists the immediate cause of the Miner's death on February 1, 2001 as "Cardiopulmonary arrest" due to "Cardiac arrhythmia," which was in turn due to "CWP [coal workers' pneumoconiosis] COPD [chronic obstructive pulmonary disease] ASHD [arteriosclerotic heart disease]." (DX 12). Dr. Patel signed the death certificate as attending physician. (*Id*.) Inasmuch as Dr. Patel's opinion has been considered above, the conclusory death certificate, while tending to support a finding of pneumoconiosis, adds little to the equation.

Third, the cytology reports of February 19 to 23, 1999 submitted by the Employer reveal no evidence of malignancy. (DX 30). These findings neither support nor undermine the claim.

Fourth, electrocardiograms submitted in connection with the instant claim taken on November 20 and 21, 2000 produced abnormal results. (DX 30). There were three reports. Tachycardia noted on November 20 did not appear on either November 21 EKG. The last EKG, performed at 12:09 p.m. on November 21, 2000, noted normal sinus rhythm, complete left bundle branch block pattern, and slight ST segment depression requiring clinical correlation to exclude ischemia. *Id.* These findings neither support nor undermine a diagnosis of pneumoconiosis.

Finally, there were three hospital records (discharge summaries) included in the record, each of which was signed by Dr. Patel. They reported findings as follows:

- **January 15, 2001**: The Miner was admitted from January 15, 2001 until January 23, 2001. He was diagnosed with the following in the discharge summary:

  1. COPD with exacerbation, acute
  2. Congestive heart failure (biventricular)
  3. Subendocardial ischemia
  4. Anemia
  5. Azotemia
  6. Peripheral vascular disease
  7. Hypertension
  8. CWP
  9. Cardiac Arrhythmia
  10. Hypercholesterolemia

- **December 24, 2000**: The Miner was admitted from December 24, 2000 to January 1, 2001. The discharge diagnoses were as follows:

    1. COPD with exacerbation, acute
    2. Right lower lobe pneumonia
    3. Recurrent nonsustained ventricular tachycardia
    4. Hyperglycemia
    5. Occult coronary artery disease with silent ischemia
    6. Azotemia
    7. Anemia
    8. Peripheral vascular disease by history
    9. CWP by history
    10. Hypertension by history
    11. Hypercholesterolemia by history
    12. Congestive heart failure
    13. Moderate aortic stenosis
    14. Hyperkalemia (transient)

- **November 20, 2000:** The Miner was admitted from November 11, 2000 to November 27, 2000. The following diagnoses were listed on discharge:

    1. Acute Respiratory distress with hypoxemia secondary to bronchitis and bronchospasm
    2. Syncope most likely related to the episodes of cough
    3. Right sided pleurisy
    4. Hypercholesterolemia by history
    5. Hypertension by history
    6. Angina pectoris from history
    7. Peripheral vascular disease by history
    8. COPD

The hospital records provide little guidance on the issue of pneumoconiosis, because the diagnoses have been stated without any explanation or data in support thereof. The diagnosis of COPD [chronic obstructive pulmonary disease] adds little without a discussion of the etiology or nature of the condition. Further, the diagnosis of CWP [coal workers' pneumoconiosis] is essentially by history rather than based upon an independent assessment. In this regard, the diagnosis of CWP cited in the December 24, 2000 hospital record states that it is "by history". Therefore, the determination was based upon prior records and not an independent finding based upon the medical evidence during the hospital visit. The January 21, 2001 record states CWP as a diagnosis without any further explanation, and the disease was not included in the November 20, 2000 record. Finally, each of the discharge summaries has been signed by Dr. Patel, and I have already discussed his opinion above. Thus, the hospital discharge summaries do not provide further support for a finding of pneumoconiosis.

Overall, I do not find that any of the additional medical evidence in this case supports a finding of pneumoconiosis. The CT scan evidence tends to negate a finding of clinical

pneumoconiosis and the discharge summaries and death certificate add little to the medical opinion of Dr. Patel, discussed above.

All Evidence on Pneumoconiosis. In considering all of the evidence, favorable and unfavorable, the evidence fails to establish the presence of pneumoconiosis under any of the individual subsections of section 718.202(a) or under the section as a whole. Taking into consideration all of the evidence on the issue of the existence of pneumoconiosis, I find that the Claimant cannot establish that the Miner had either clinical or legal pneumoconiosis as defined by the regulations.

CONCLUSION

Inasmuch as the Claimant cannot establish the presence of pneumoconiosis, this claim fails because a requisite condition of entitlement has not been met. A separate discussion and analysis of the remaining issues raised in this claim is therefore unnecessary.

ORDER

IT IS HEREBY ORDERED that the claim of Virginia Bea Matney for black lung benefits be, and hereby is, **DENIED.**

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of the Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits at the Frances Perkins Building, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.